VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 25, 2012

Ms. Jessica Jennings, Administrator
Saint Albans Healthcare and Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Provider #: 475021

Dear Ms. Jennings:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 16, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual re-certification survey was conducted on May 14 through May 16, 2012. The following regulatory citations resulted.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to develop comprehensive plans of care indicating specific interventions to address the identified needs of two Residents regarding activity preferences, behavior management and management of an existing pressure ulcer. This affected two (#16, #20) of 22 stage two sampled	F 279	F279 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. Resident #20's care plan was updated to address the actual pressure wound and the interventions for treatment. Resident # 16's care plan was updated to include interests/activity preference to assist staff in redirecting resident, non-pharmacological interventions to attempt prior to medication administration. Activity preferences from the activity assessment were added to the comprehensive care plan. Residents residing in the Rehab and LTC neighborhood have the potential to be affected by this deficient practice. Nurses and Recreation Director will be educated regarding the centers policy for comprehensive care plans.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/4/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 residents. Findings include: 1). Per record review on 5/16/12, Resident #20 was admitted to the facility on 4/24/12, with a Stage 2 Pressure area on their coccyx. Although treatment was started and documented as being completed as ordered, the care plan was not developed to reflect the actual pressure wound and the interventions put in place to treat it. Per interview on 5/16/12 at 10:30 AM, the Unit Coordinator confirmed that the care plan did not address the actual pressure wound and the interventions to treat it. 2). Review of the clinical record for Resident #16, revealed an admission date of 01/18/2012 and diagnoses of dementia with psychotic features, chronic pain, anxiety and depression. Review of the medication regimen revealed an order for as needed lorazepam (anti anxiety medication) every eight hours as needed. The medication administration record revealed this medication was administered five times between 05/01/12 and 05/14/12. Review of the Resident Care Plan developed 01/18/12 and last reviewed on 05/04/12, revealed a plan of care for wandering behaviors and indicated if staff were unable to redirect the Resident, they should provide supervision until they were able to redirect. The plan of care contained no detail of how the Resident may be redirected or gave any indication of the Resident's interests or activity preferences to aid staff in providing successful redirection. A plan of care for behaviors, including physical aggression, verbal aggression,	F 279	Care plan audits will be conducted weekly x 4 then monthly x 3. This will be monitored by the DON and/or her designee. Results of the audits will be presented At CQI for further evaluation and Recommendations. Corrective action will be completed By June 16, 2012. F279 POC accepted 6/7/12 MHaqmsRN/ PMcstaRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 resisting care and treatment, banging head on the wall, and wandering was noted to have an intervention to medicate as ordered by the physician and monitor for side effects, and to redirect the Resident when the Resident becomes physically aggressive. The plan of care contained no detail of how the Resident may be redirected or gave any indication of the Resident's interests or activity preferences to aid staff in providing successful redirection. A plan of care for risk of complication related to the use of psychotropic drugs was noted to have interventions including to complete a behavior monitoring flow sheet, obtain a psychiatric/psychological evaluation as ordered and provide informed consent to the Resident or healthcare decision maker. The plan of care did not contain non pharmacological interventions or information related to activities of interest that may calm or redirect the Resident that may be attempted prior to the administration of prescribed anti anxiety medications. There was no plan of care located that addressed the activity preferences, likes or dislikes of the Resident. During interview of Resident #16 on 5/14/12 at 1:52 P.M., the Resident stated "I am not compatible with other people and activities". During each observation between 05/14/12 and 05/16/12, Resident #16 was in bed, in a darkened room with the privacy curtain partially closed and the television on. Interview of the Licensed Practical Nurse (LPN), Unit Manager on 5/16/12 at 9:48 A.M., revealed that Resident #16 comes out of the room once in a while, wanders, and does not participate in any facility activities. The LPN was unable to locate a	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 plan of care that indicated what types of activity Resident #16 had an interest in or what activities or topics of conversation could be used to redirect the attention of Resident #16. The LPN did not identify any interests of Resident #16 other than watching television. Interview of the activity director (AD) on 5/16/12 at 10:00 A.M., revealed that a detailed activity assessment had been completed on 1/23/12. The assessment indicated that Resident #16 was interested in easy listening music and pets. Resident #16 enjoyed watching television, going outside when weather permitted and read a newspaper daily prior to admission to the facility. The AD indicated that the Resident was a veteran and spent a lot of time with veteran peers prior to admission. The AD indicated an awareness of behavioral challenges presented by Resident #16 and acknowledged the assessment information may be helpful to staff during behavioral outbursts. The AD stated that a plan of care was not developed because Resident #16 did not trigger activities on the minimum data set assessment.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to assure that the plan of care was revised to reflect a new development in behavior for 1 of 22 residents sampled (Resident #21). Findings include: Per record review on 5/15/12, Resident #21 was admitted to the dementia unit in March 2012. A nurse's note dated 3/16/12 documented that the Resident #21 was out of bed in his/her room at 3:30 AM, moving toiletry items from the sink to the floor, and attempting to drink the shampoo. The nurse documented that s/he took the shampoo away and guided the resident back to bed. Per review of the plan of care for Resident #21, there was no update made to reflect the incident of the new behavior of attempting to drink non-food items. Per interview on 5/16/12 at 10:20 AM, the Unit Coordinator confirmed that the plan of care did not contain any information related to this behavior observed by the nurse on 3/16/12.	F 280	Resident #21's care plan was updated under his behaviors for safety awareness to reflect the incident of attempting to consume shampoo. Resident's toiletries were removed from his bedside on 5/16/12 and placed out of residents reach. The nurse writing the note on 3/16/12 was provided with a performance improvement plan and educated on the importance of relaying information per the 24 hour communication report and care planning on 5/17/12. All nurses will be educated on the center's policy for Care Planning. Residents receiving care from this nurse are at risk for this deficient practice. Care plan audits will be conducted weekly x 4 then monthly x 3. This will be monitored by the DON and/or her designee. Results of the audits will be presented At CQI for further evaluation and Recommendations. Corrective action will be completed By June 16, 2012.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F280 POC accepted 6/7/12 MHiggins RN/ PNCotaRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement an intervention in the plan of care for 1 of 22 residents sampled (Resident #21). Findings include: Per record review on 5/15/12, Resident #21 acquired a deep tissue injury (DTI) to the right buttock, first noted on 3/16/12 in a skin assessment. Treatment included observing the area daily, documenting a skin assessment weekly on the treatment sheet, and use of a pressure relieving cushion to be placed on the chair when the resident sits "at all times". The weekly wound assessments documented that the DTI was still present at the time of survey, and the interventions were still in place. Per observation on 5/16/12 at 8:25 AM, Resident #21 was sleeping while seated at the table in the dining room for breakfast, with no pressure relieving cushion placed on the chair seat. On 5/16/12 at 8:27 AM, the Unit Coordinator confirmed that the pressure relieving cushion was supposed to be on the chair at all times when the resident was seated , and that it was not there at the time of the observation. An LNA was sent to the resident's room to retrieve the cushion from the closet to place it on the chair.	F 282	F282 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. The resident's pressure relieving devise was placed under resident on 5/16/12 per resident's care plan. Residents on the dementia unit with alteration in skin integrity are at risk for this deficient practice. The nurses and LNA's on the dementia neighborhood have been educated on the importance of implementing interventions for the resident's written plan of care. Care plan intervention audits for chair Cushions related to skin integrity will be conducted five days per week x 4 and then monthly x 3. This will be monitored by the DON and/or her designee. Results of the audits will be presented At CQI for further evaluation and Recommendations. Corrective action will be completed By June 16, 2012.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

F282 POC accepted 6/7/12
MHiggins RN | RNcofaRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to assure that a safe environment was provided for 1 of 22 residents sampled (Resident #21). Findings include: Per record review on 5/15 and 5/16/12, Resident #21 was admitted to the facility on 3/7/12, with a diagnosis of dementia. The resident resides on the Dementia Special Care unit of the facility. During the three days of survey, Resident #21 was observed wandering on the unit, and sometimes in his/her room unsupervised. Per review of the nurse's notes, on 3/16/12 the resident was up in his/her room at 3:30 AM, observed by the nurse to be moving items from the sink to the floor, and attempting to drink the shampoo from the bottle. The nurse documented that s/he took the shampoo from the resident and guided him/her back to bed. There was no documentation to indicate that the nurse removed any of the hygiene products from the room at that time. Per review of the plan of care for Resident #21, there was no update to the care plan to address the previously undocumented behavior of attempting to consume non-food items. Per observation on 5/16/12 at 10:20 AM, the	F 323	F323 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. Resident's toiletries were removed from his bedside on 5/16/12 and placed out of residents reach. The nurse writing the note on 3/16/12 was provided with a performance improvement plan and educated on the importance maintaining resident safety, relaying information per the 24 hour communication report and care planning on 5/17/12. Identified residents on the dementia unit that are at risk for consuming shampoo have the potential to be affected by this Deficient practice. Nursing staff will be educated on assuring a safe environment per the center's Physical Environment/ Safety Standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 bedstand/cupboard next to the bed of Resident #21 had a basin inside the unlocked cabinet that contained a number of personal hygiene products including shampoo/body wash, skin care creams, and mouthwash. All of these products were labeled as " for external use only " and/or had warnings to seek medical attention if consumed. Per interview on 5/16/12 at 11:05 AM, the Unit Coordinator confirmed the presence of the hygiene products still in the bedside cabinet, and that they were easily accessible to the resident, and were a potential safety concern.	F 323	Audits will be completed daily x 5 Days/week for this resident to assure that his safety is maintained in his environment. Results of the audits will be presented At CQI for further evaluation and Recommendations. Corrective action will be completed By June 16, 2012.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F323 POC accepted 6/7/12 MH RN/ AMcLaurin F329 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. Non-pharmacological activities were added to this resident's behavior plan of care to attempt to redirect resident prior to administration of anti-anxiety medication. Residents receiving PRN anti-anxiety medication are at risk of this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure that one Resident did not receive unnecessary doses of as needed anti anxiety medication without adequate attempts to manage behaviors with non pharmacological interventions, and without adequate monitoring of the effectiveness of the medications administered. This affected one (#16) of ten stage two Residents' drug regimens reviewed for the use of unnecessary medications. Findings include: Review of the clinical record for Resident #16, revealed an admission date of 01/18/2012 and diagnoses of dementia with psychotic features, chronic pain, anxiety and depression. Review of the medication regimen revealed an order for as needed lorazepam (anti anxiety medication) every eight hours as needed. Review of the Resident Care Plan developed 01/18/12 and last reviewed on 05/04/12, revealed a plan of care for wandering behaviors and indicated if staff were unable to redirect the Resident, they should provide supervision until they were able to redirect. The plan of care contained no detail of how the Resident may be redirected or gave any indication of the Resident's interests or activity preferences to aid staff in providing successful redirection. A plan of care for behaviors, including physical aggression, verbal aggression, resisting care and treatment, banging head on the wall, and wandering was noted to have an intervention to medicate as ordered by the	F 329	Nurses will be educated on the center's policy for Medication Administration/ documentation, Psychopharmacological Medication Use, and Behavior Monitoring. The nursing staff will be educated on providing non-pharmacological interventions prior to medication administration. MAR & Behavior audits will be completed Weekly x 4 weeks and then monthly x 3 to assure that residents have not received unnecessary medications and care plans reflect non-pharmacological interventions are used. Results of the audits will be presented At CQI for further evaluation and Recommendations. Corrective action will be completed By June 16, 2012. F329 POC accepted 6/7/12 MHiggins RN/ QMcotaRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 physician and monitor for side effects, and to redirect the Resident when the Resident becomes physically aggressive. The plan of care contained no detail of how the Resident may be redirected or gave any indication of the Resident's interests or activity preferences to aid staff in providing successful redirection. A plan of care for risk of complication related to the use of psychotropic drugs was noted to have interventions including to complete a behavior monitoring flow sheet, obtain a psychiatric/psychological evaluation as ordered and provide informed consent to the Resident or healthcare decision maker. The plan of care did not contain non pharmacological interventions or information related to activities of interest that may calm or redirect the Resident that may be attempted prior to the administration of prescribed anti anxiety medications. The Medication Administration Record (MAR) revealed one dose of lorazepam 0.5 milligrams (mg) was administered on 05/01/12, 05/03/12, 05/06/12, 05/07/12 and 05/14/12. Review of the behavior/intervention monthly flow record, MAR, and nurses notes on the dates of the medication administration revealed that on 05/03/12 there was no documentation of the reason the medication had been administered or the results or the Resident's response to the medication. On 05/06/12 these documents indicated no results or response to the medication administered. No documentation of attempted non pharmacological interventions were noted. On 05/07/12 the records indicated by the initials of the nurse, that a dose of lorazepam had been administered. There was no documentation of the time, the reason, the results or response to the medication	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 or any attempted non pharmacological interventions. Interview of the Licensed Practical Nurse (LPN) unit manager on 5/16/12 at 9:48 A.M. confirmed the above findings. The Director of Nursing (DON) reviewed the documentation and confirmed on 5/16/12 at approximately 11:30 A.M. that there was no documentation of the need for the administration of the as needed anti anxiety medication, response to the medication administered or non pharmacological intervention that had been attempted prior to medicating Resident #16 on 05/03/12, 05/06/12 and 05/07/12.	F 329		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure food was provided at the proper temperatures. Findings include: Per review of the kitchen steam table and beverage temperature logs for April 2010 on 5/16/12 at 11:12 AM, the facility failed to ensure foods were served at the proper temperatures. There was no documentation of temperatures taken for 7 of 90 opportunities for hot foods and	F 364	F364 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. All residents have the potential to be at risk for this deficient practice. The dietary staff will be educated on the center's policy regarding Food Handling and Thermometer Usage. The Food Service Director will audit The Food Production sheets to assure that food was provided at the proper temperatures weekly x 4 and then monthly x 3. Results of the audits will be presented at CQI for further evaluation and recommendations. Corrective action will be completed By June 16, 2012.	

F364 POC accepted 6/7/12
MHiggins RN | DMeotaRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 11 55 of 90 opportunities for chilled beverages between 4/1/12 - 4/30/12. The Food Services Director (FSD) stated that both beverages and hot food temperatures should be taken at each meal service and confirmed 7 hot food and 55 beverage temperature recordings had not been taken or documented per facility policy and safe food handling practice.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to assure that food was served under sanitary conditions. Findings include: 1).Per observation and staff interview during the lunch service preparation of trays on 5/14/12 a food service worker was observed preparing food trays and handling plates and utensils while wearing gloves. The food service worker used a telephone without removing or changing his/her gloves. Additionally s/he was observed adjusting his/her glasses and wiping his/her nose without changing his/her gloves. When questioned as to if s/he would normally change gloves after using	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING _____ B. WING _____	05/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 the phone or touching her face s/he replied "I don't know." The finding was confirmed with the Food Services Director at 11:45 A on 5/14/12. 2).Per observation, during lunch service on 5/14/12 at 11:50 A,a Line Server was observed placing food on plates. A plate was delivered to a resident seated at a table in the dining room. The plate contained a piece of boneless pork rib and vegetables. A family member returned the plate to the service line requesting that the resident have the ground meat version instead. The server took the plate back from the family member, returned the pork filet to the serving pan and replaced it with ground meat. There were still residents to be served from the serving pan. The pork returned to the serving tray had been left, unobserved at a resident table. The findings were confirmed, at that time, with the Food Service Director, who instructed the line server to stop serving from the pan and discard the remaining meat.	F 371	F371 St. Albans Health and Rehab Center provides this plan of correction without admitting or denying the validity or existence of the allege deficiency. The plan of correction is prepared and executed solely because it is required by federal and state law. The mentioned employee has been provided with a Performance Improvement plan regarding infection control and food handling. All residents have the potential to be Affected by this deficient practice. This employee has been educated on the center's policy regarding hand washing and food handling. The Food Service Director will audit this employee for proper food handling to assure sanitary conditions weekly x 4 and then monthly x 3. Results of the audits will be presented at CQI for further evaluation and recommendations. Corrective action will be completed By June 16, 2012.	

F371 POC accepted 6/7/12
MHiggins RN | Director RN